DEPARTMENT OF STATE REVENUE
LETTER OF FINDINGS: 02-0311
Indiana Corporate Income Tax
For the 1998, 1999, and 2000 Tax Years

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ISSUES

I. Inclusion of Capitation Payments in Taxpayer's Reserve Exclusion – Gross Income Tax.

Authority: 45 IAC 1-1-68; 45 IAC 1.1-1-14; 45 IAC 1.1-1-14(a); 45 IAC 1.1-1-14(j); Tax Policy Directive #9, July 1995; Black's Law Dictionary (7th ed. 1999).

Taxpayer maintains that, for purposes of computing its gross income tax liability, it is entitled to include capitation payments in its reserve exclusion.

II. Credit for Payments Made to the Indiana Comprehensive Health Insurance Association.

Authority: IC 6-8.1-5-1(b); IC 27-8-10-2.1(a); IC 27-8-10-2.1(f); IC 27-8-10-2.1(g); IC 27-8-10-2.1(n)(1); IC 27-8-10-2.1(n)(2).

Taxpayer argues that the audit erred when it disallowed an income tax credit which taxpayer had claimed for payments made to the Indiana Comprehensive Health Insurance Association (ICHIA).

STATEMENT OF FACTS

The taxpayer is an Indiana Health Maintenance Organization (HMO) currently undergoing liquidation. As part of the liquidation proceedings, the taxpayer's income tax returns for 1998, 1999, and 2000 were reviewed. The audit made two adjustments to the returns which resulted in an assessment of additional corporate income taxes. Taxpayer protested the audit's conclusions, an administrative hearing was conducted, and this Letter of Findings followed.

DISCUSSION

I. Inclusion of Capitation Payments in Taxpayer's Reserve Exclusion – Gross Income Tax.

Before undergoing liquidation, the taxpayer was a health maintenance organization (HMO). As such, it provided health care services to a defined, enrolled population of insureds. Individual insureds were each charged an annual premium which was not directly related to the services the insureds received during a particular time period.

The taxpayer contracted with independent third-party physicians to provide the insureds the necessary health care services. The insureds were free to choose one of these participating physicians as the individual insured's primary health care provider. The taxpayer compensated the participating physicians on a capitation basis; for each insured who had chosen a particular physician, that physician would receive a designated amount each month. The amount of capitation payments each physician received was unrelated to the number of times the individual insureds obtained medical services.

In 1985, taxpayer – together with a number of similarly situated insurance companies – sought and received a Revenue Ruling from the Department of Revenue. The petitioners sought and received a determination that, under 45 IAC 1-1-68, in reporting their taxable receipts, the petitioners as HMOs were entitled to deduct from their gross income an amount equal to the HMO's gross premiums, multiplied by the ratio of claims incurred, to premiums earned during the taxable year. For simplicity's sake, this amount will be hereinafter referred to as the "reserve exclusion." Specifically the Department ruled as follows:

> [I]t is apparent to the Department that HMOs should be treated analogously to traditional health insurance carriers. Accordingly, under the authority of Regulation 45 IAC 1-1-68, [petitioners] shall be permitted, in computing their gross income tax liability, to exclude from gross enrollment fees (i.e., premium income) a corresponding amount computed by multiplying their gross fee premium income by the ratio of medical and hospital care payments made by the HMO to premiums earned by the HMO on an annual basis.

However, following an audit of taxpayer's income tax returns, the audit determined that taxpayer erred in calculating its reserve exclusion. The audit found that "capitation payments were erroneously included." The audit stated that the capitation payments should not have been included because the "capitation payments were a fixed prepayment to doctors, hospitals, etc. to cover members' medical needs regardless of the actual number of services provided to each person." Essentially, because the capitation payments were not an amount "at risk," the audit concluded that the capitation payments should not have been included in the reserve account.

The 1985 Revenue Ruling was issued on January 16, 1985. Pursuant to Tax Policy Directive #9, July 1995, the 1985 ruling was "declared null and void and of no effect for tax years beginning after December 31, 1996." Nonetheless, it is reasonable to assume that the 1985 Revenue Ruling correctly interpreted the pertinent gross income tax regulations in effect at the time the original ruling was first issued.

The 1985 Revenue Ruling interpreted 45 IAC 1-1-68, "Explanation of Lines 1 through 5: Underwriting Income" under that portion of the regulation related to "Accident and Health Insurance." In pertinent part, that section reads as follows:

> 3. For classes of business on which reserves comparable to life insurance reserves are maintained – use company records of net premiums for such business . . . with respect to such classes of business as noncancellable accident and health insurance.
>
> 4. For other accident and health business or hospitalization multiply the gross premiums for such business included in line 1, Column 1, by the ratio of claims incurred . . . to premiums earned . . . for such other accident and health insurance, e.g., groups, and other short-term cancelable accident and health policies.

The 1985 Revenue Ruling interpreted the 45 IAC 1-1-68 to mean that traditional health insurers were entitled to exclude from their gross income a reserve amount sufficient to pay its insureds' anticipated health care costs. For example, if an individual insured paid $2,000 for one year's coverage, the $2,000 would constitute the insurer's "gross premiums." Thereafter, the traditional insurer was entitled – based upon its past claims experience – to exclude from its gross income an amount necessary to pay the insured's anticipated medical costs for the covered year. For purposes of this example, the insured might determine that $1,500 was necessary to pay those anticipated costs. The amount of its "reserve exclusion" would, of course, be based upon the insurer's claim experience over a very large number of its insureds. Based upon that larger pool of insureds, the $1,500 individual reserve – multiplied by the total number of similar insureds – would be expected to cover the total medical expenses for the entire pool.

For reasons not relevant here, HMO's operate differently. Assuming that one of taxpayer's own insureds paid taxpayer $2,000 for one years worth of individual health care coverage, the taxpayer would thereafter make capitation payments to the health care provider selected by that particular insured. The taxpayer might make $100 monthly capitation payments to the physician; in this example, the physician would receive $1,200 over the course of that year. The amount of capitation payments would be based upon on the anticipated health care costs for that single insured. However, the physician would receive the $1,200 regardless of the number of times the insured sought and received services from the provider.

The language contained within the 1985 Revenue Ruling is straightforward. The ruling states that, "HMOs should be treated analogously to traditional health insurance carriers." The reserve amount, maintained by traditional health insurers, is analogous to the capitation payments paid by HMOs to their physicians. Although the amount of the reserve might be considered an amount "at risk," in reality, the difference between the reserve amount and the capitation payments is simply one of semantics and is not reflected in practical reality. Both the reserve amount and the capitation payments reflect the insurers' determination – based upon past claims experience – of the cost of providing medical services for a particular pool of insureds. Regardless of the appropriateness of providing such an exclusion, 45 IAC 1-1-68, as interpreted by the 1985 Revenue Ruling, permits both traditional health insurers and HMOs to treat, for gross income tax purposes the amount paid to health care providers, as "pass through" income having no gross income tax effect for the traditional health insurer *or* the HMO.

However, the taxpayer lodges its protest based upon gross income tax assessments for 1998, 1999, and 2000. The determination above applies only to the 1998 assessment made against the taxpayer because, on January 1, 1998, the regulations governing the gross income tax law were

revised. Thereafter, 45 IAC 1.1-1-14 governs the issues raised by taxpayer concerning the capitation payments.

The regulation states, in relevant part, as follows:

> Except as otherwise provided in this section, "gross income of an insurance carrier" means the total amount of premiums, interest, dividends, commissions, rents, and other earnings with respect to conducting the business of an insurance. The term does not include the following: (1) The amount of gross earnings which becomes or is used to maintain a policy reserve or other policy liability, to the extent that the insurance carrier is required to maintain the policy reserve or other policy liability by the department of insurance. 45 IAC 1.1-1-14(a).

Also relevant to taxpayer's argument is the 45 IAC 1-1-14(j) which states that "[f]or purposes of this section and 45 1.1-6-11, a health maintenance organization licensed under IC 27-13 shall be treated the same as an insurance carrier selling accident and health insurance on all income from providing prepaid health care."

Because the 1985 Revenue Ruling expired in 1995 and, because 45 IAC 1-1-68 was replaced in 1999, 45 IAC 1.1-1-14(a), (j) governs taxpayer's 1999 and 2000 claims. 45 IAC 1.1-1-14(a) permits an insurer to exclude from its gross income an amount sufficient "to maintain a policy reserve." A "policy reserve" is defined as "[a]n insurance company's reserve that represents the difference between net premiums and expected claims for a given year." Black's Law Dictionary 1308 (7th ed. 1999). More generally, a "reserve" is defined as "a fund of money set aside by a bank or an insurance company to cover future liabilities." Id.

Resorting again to the example first cited above – in which the insured paid a yearly premium of $2,000 and the HMO insurer made capitation payments of $1,200 – the amount of "net payment" is $2,000 and the amount of "expected claims" is $1,200. The difference between the two figures is, of course, $800. The $800 represents the insurance company's cost of operations, profits, and those medical costs which are not covered by the capitation payments.

It is apparent that taxpayer's capitation payments do not come within the designation of a "policy reserve" as defined under 45 IAC 1.1-1-14(a) because those particular payments are not "set aside by . . . an insurance company to cover future liabilities." As set out in the prior example, the HMO insurer would be entitled to set aside a portion of the $800 to pay for those medical expenses not covered by the capitation payments. It is this amount – not the capitation payments – which may be included within the reserve exclusion allowed under 45 IAC 1.1-1-14(a). The 1999 and 2000 capitation payments are within the definition of "gross income of an insurance carrier" and are properly subject to the gross income tax.

Therefore, based upon the 1985 Revenue Ruling and its interpretation of 45 IAC 1-1-68, taxpayer's capitation payments may be included in its 1998 gross income tax reserve exclusion. However, based upon the fact that the 1985 Revenue Ruling expired in 1996 and that 45 IAC 1.1-1-14 replaced the prior regulation, taxpayer is not entitled to include the capitation payments in its 1999 or 2000 gross income tax reserve exclusion.

FINDING

Taxpayer's protest is sustained in part and denied in part.

II. Credit for Payments Made to the Indiana Comprehensive Health Insurance Association.

Taxpayer was a member of the Indiana Comprehensive Health Insurance Association. (*Hereinafter* "ICHIA"). ICHIA is a non-profit legal entity that provides health insurance to Indiana residents who cannot obtain private insurance. IC 27-8-10-2.1(a). All Indiana health insurance carriers, such as taxpayer, which provide health insurance or health care services within the state are required to be members of ICHIA. Id. Because ICHIA is required to charge rates which "may not be unreasonable in relation to the benefits provided . . ." (IC 27-8-10-2.1(f)), ICHIA usually generates losses rather than profits. ICHIA recovers those losses by making assessments to its members in proportion to the amount of health insurance premiums that the members earn during each year. IC 27-8-10-2.1(g). However, each member is thereafter permitted to take a credit against its state income tax liability up to the amount of the assessment paid to ICHIA. IC 27-8-10-2.1(n)(1). Alternatively, the member is entitled to recoup the assessment by passing along the cost to its own insureds. IC 27-8-10-2.1(n)(2). However, the members may not do both; the insurer may either take the credit against their income tax *or* pass the ICHIA assessment along to its own insureds in the form of increased premium costs.

The audit determined that taxpayer had claimed the credit in calculating its gross income. Although taxpayer was able to provide documentation that the amounts claimed were actually paid to ICHIA, it was unable to provide verification that the amounts had not also been included in its premium base. Specifically, taxpayer was asked to provide a statement from the head of its actuarial department attesting that the ICHIA payments were not included in the premium base. However, taxpayer's representatives were unable to do so because, according to the representatives, taxpayer's former officers were unwilling to supply the requested information.

Taxpayer argues that the ICHIA payments could not have been included in the premium base because taxpayer did not charge premium rates sufficient to recoup its expenses. According to taxpayer, this is evidenced by the fact that taxpayer accumulated a substantial retained deficit at the time it entered into liquidation.

The fact that the taxpayer sustained substantial losses is not alone sufficient to warrant a finding that the assessment was incorrect. It is entirely possible that taxpayer, despite indications that it incurred substantial financial losses, erroneously claimed the ICHIA payments as a credit on its income tax and erroneously included the payments in its premium base.

Under IC 6-8.1-5-1(b), the taxpayer bears the burden of demonstrating that the proposed assessment is incorrect. The statute establishes that "[t]his notice of proposed assessment is prima facie evidence that the department's claim for the unpaid tax is valid. The burden of proving that the proposed assessment is wrong rests with the person against whom the proposed assessment is made."

Taxpayer submitted affidavits purporting to establish that it did not recoup the ICHIA payments in its premium rate amounts and that it was legitimately entitled to claim credit against its income tax in accordance with IC 27-8-10-2.1(n)(1). Taxpayer included an affidavit from the Commissioner of the Indiana Department of Insurance. The Commissioner somewhat circumspectly stated that the "[Commissioner was] in no manner acknowledging the validity of the [taxpayer's] claim . . . ." However, the Commissioner also noted that taxpayer's contention, that it was unable to recoup the ICHIA payment via increases to its premium rates, was consistent with taxpayer's earlier assertions set out in an action brought by taxpayer – together with two other HMOs licensed in the state of Indiana – against ICHIA and the Commissioner.

Taxpayer submitted an affidavit prepared by the taxpayer's former vice-president and general manager. The affiant's former responsibilities included "overall development of the operating budget and strategic plan for the company." In addition, the affiant stated that she was "privy to and participated in the process whereby [taxpayer] developed its premium rates . . . ." Further, the affiant stated that, "it was not economically feasible for [taxpayer] to increase premiums to recover ICHIA assessments above its annual tax credits" and that "[t]o increase premiums to recover the excess amount of accrued ICHIA assessments would have put [taxpayer] at a competitive disadvantage in a highly competitive market . . . ." The affiant further stated that "there was never a line item added during the development of [taxpayer's] premium rates, or during the filing of such rates with the Indiana Department of Insurance, to recoup ICHIA Assessments pursuant to Ind. Code § 27-8-10-2.1(n)(2)."

Taxpayer submitted an affidavit prepared by a consulting actuarial. The actuarial was employed by the Indiana Department of Insurance. During that time, the actuarial was required to review rate filings submitted by various HMOs including taxpayer's own rate filings. The actuarial reviewed the taxpayer's rate filings which would have been effective in 1998, 1999, and 2001. The actuarial indicated that there was no reference in the rate filings "indicating or otherwise suggesting that [taxpayer], in accordance with the terms of I.C. § 27-8-10-2.1(n), included in its premium rate calculations amounts sufficient to recoup the . . . ICHIA assessments, or any portions thereof."

Under IC 6-8.1-5-1(b), the taxpayer has met its burden of demonstrating that the proposed assessment is incorrect.

FINDING

Taxpayer's protest is sustained.

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